Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Lystoll Lodge Nursing Home
Name of provider:	Lystoll Lodge Nursing Home
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	22 April 2026
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0050562

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Lystoll Lodge Nursing Home is situated in the countryside, approximately one mile outside the heritage town of Listowel. The centre provides 24-hour nursing care, which is led by the person in charge, who is a qualified nurse. The centre is a two story premises and is registered to accommodate 48 residents. Bedroom accommodation consists of 28 single bedrooms and ten twin bedrooms. There is a variety of communal space, which includes a dining room on the ground floor and three sitting rooms, as well as an internal garden. The centre can accommodate both male and female residents requiring continuing care, respite care, convalescence care, dementia care, psychiatric care and end-of-life care. Admissions to Lystoll Lodge Nursing Home are arranged by appointment, following a pre-admission assessment of needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 22 April 2026	12:40hrs to 20:40hrs	Siobhan Bourke	Lead
Thursday 23 April 2026	09:00hrs to 16:00hrs	Siobhan Bourke	Lead
Wednesday 22 April 2026	12:40hrs to 20:40hrs	Caroline Connelly	Support
Thursday 23 April 2026	09:00hrs to 16:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This was a two day unannounced risk inspection, by two inspectors of social services, carried out in response to unsolicited information received to the office of the Chief Inspector that raised concerns regarding the quality and safety of care provided to residents. During the two days, the inspectors met with many of the residents and spoke with 14 residents in more detail. Inspectors met with seven visitors during the two days. Residents and relatives spoke very positively regarding the kindness and care staff provided, however they raise concerns regarding staffing shortages with resultant delays in care particularly in the early evenings, night time and at weekends with the inspectors. A number of visitors also identified that clothing and personal items had gone missing for their relatives and although they had identified this with management, it had continued to occur. These issues will be discussed further in the report. The overall findings of the report identified a centre with poor governance and oversight that required significant action.

The inspectors arrived unannounced to the centre at lunch time on day one of the inspection and remained in the centre until after the night staff were on duty. The inspectors then returned to the centre the following day. The inspectors walked around the centre to meet with residents, staff and observe the daily routines in the centre. The inspectors saw that the newly registered day rooms were fully operational on both floors, providing residents much more space and room to enjoy their surroundings. Both rooms were furnished with large plants and nice curtains to give the rooms a homely feel.

On the ground floor, inspectors saw that residents were enjoying a social dining experience in the dining room, where tables were appropriately set and residents enjoyed eating together with their friends. This was in stark contrast to the dining experience for residents on the first floor. Here, despite the addition of a new dining room which could facilitate at least eight residents, there were only four residents present and eight other residents were seen to have their meals in the day room where they spent the day, not allowing them a chance for motion or a change of scenery. When the inspectors enquired of the staff why this practice continued to happen they were informed that one resident required a hoist to transfer, therefore staff did not move the resident to the dining room, which would not be in keeping with respecting a resident's choice. There was no reason provided for other residents remaining in the day room. The four residents that did attend the upstairs dining room upstairs were observed sitting at tables that were bare of table cloths or condiments. Residents sitting at the same table were served their meals at different times, whereby one resident had long finished their dinner before their table companions even received theirs. One of the residents became upset and asked "am I not getting any food today." The system for delivering food to residents dining upstairs meant only four meals came up together on a trolley, the provider said they

would address this with the reintroduction of a hot trolley to ensure all meals could be delivered at the same time preventing these untimely delays.

The inspectors observed that there were plenty of staff available to assist residents but the current system of meal delivery did not ensure staff could do so in a timely manner. The inspectors saw that residents were offered a choice of main courses for the lunch time and evening meal. Residents were very complimentary to the inspectors regarding the choices available at mealtimes and the home baked goods such as scones and cakes available to them.

Staff were observed interacting with residents, in a kind and compassionate way and assisting them as required. Some of the residents living in the centre had a diagnosis of a cognitive impairment and could not converse with inspectors. The inspectors saw that these residents were very comfortable in the company of staff who appeared to be aware of their preferences and dislikes.

Lystoll Lodge Nursing Home is a designated centre for older people situated in a rural setting, outside the town of Listowel, County Kerry. The centre is a two storey purpose built nursing home, which is registered to accommodate 48 residents. There were 48 residents living in the centre on the days of this inspection. There were bedrooms to accommodate 30 residents on the first floor and 18 on the ground floor, with a lift available for residents' use. A number of wardrobes had been fitted in some of the bedrooms and the inspectors saw that televisions had been repositioned in a number of residents' bedrooms.

On the first day of inspection, the inspectors saw that an escape route on the ground floor was cluttered with a chair, dust mats and planks of wood and was not clear in the event of an emergency. An immediate action was issued and actioned by the provider with regard to ensuring this exit was clear. As identified on the previous number of inspections, the layout of some of the privacy curtains in shared rooms, did not ensure that the privacy of both residents could be maintained, if the curtains were closed. The provider informed the inspectors that new curtain poles and curtains were in place, however, in a number of rooms the privacy curtains were the wrong size, or did not enclose the bed space sufficiently, to provide privacy for residents in twin bedrooms. Also in some residents' bedrooms, wardrobes were in the bed space of other residents which made them difficult for residents to access, if the other resident had their curtains closed or were receiving personal care

The inspectors attended the night time handover and detailed information was shared with the night staff to enable them to provide care to the residents. There was a staff member working 18.00 to 20.00hrs to assist residents to bed which was a good comfort to the residents. From speaking with staff and a review of the rosters, this shift was only covered four evenings a week, so on other days there was a deficit in staffing. This is discussed and actioned further in the report.

The inspectors were informed that the activity staff member was on leave and was not replaced by another staff to provide social stimulation for the residents. There were some activities going on, including art therapy, for a number of residents; but

there continued to be long periods of the day where there was very little stimulation for residents. The inspectors saw residents returning to bed early in the evening, some bedrooms didn't have TV's on and residents were in their rooms awake with nothing to do.

On the second morning of the inspection, the inspectors did a walk around the centre with the Assistant Director of Nursing (ADON). The inspectors observed many beds unmade and found there was a lack of sheets and towels for residents care. There was not a supply in the laundry so an immediate action was issued to the provider and a new supply of bed linen and towels were made available from a storage unit. A torn and badly stained mattress was seen in one resident's bedroom that required removal and disposal but this had not occurred until after the inspectors identified same. The inspectors observed a number of other issues with the premises including stained and damaged flooring, two call bells not working so residents could not call for assistance these and other issues are all discussed further in the report.

The inspectors also noted a musty unclean smell in a number of parts of the centre despite there being two cleaning staff on duty. It was also identified that cleaner and store rooms had boxes on the floor impeding effective cleaning.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations in this report.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social service to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended) and to review unsolicited information received by the Chief Inspector, pertaining to serious concerns regarding the care and safety of residents.

The findings of this inspection were that the registered provider had failed to put effective management structures and systems in place to ensure that the service provided was safe and appropriately monitored. Ineffective management systems of monitoring and oversight, significantly impacted on the quality and safety of the care provided to residents.

Inspectors reviewed the detail of unsolicited information received by the Chief Inspector in relation to poor standards of care provided in the centre, and the associated risk to the care and welfare of residents. Much of this information was substantiated on this inspection.

Significant action was required by the provider to ensure appropriate oversight and management arrangements were in place. An immediate action was issued to the provider on the first day of inspection as an escape route, was observed to be obstructed with a chair, dust sheets and planks of wood,which could cause delays in escape from the centre,in the event of a fire. Tins of paint and painting supplies were also stored under the stairs in close proximity to the exit, which was a fire risk. A second immediate action was required by the provider on day two, to ensure there was adequate supply of linen and towels available in the centre. Both were addressed by the provider during the inspection.

The registered provider of the centre is Lystoll Lodge Nursing Home Limited, which comprises two company directors. Both directors are engaged in the running of the centre, with one director involved in the operational and non-clinical management of the centre and the second director directly involved in the daily maintenance of the centre. The provider had submitted an application to vary condition one of the centre's registration 26 January 2026, as two new offices had been commissioned one on each floor and the oratory had moved from the ground floor to the first floor. These rooms were operational on the days of inspection without the required application being granted.

The person in charge was on unplanned leave during the days of inspection and an assistant director of nursing was deputising in their absence. The onsite clinical management also comprised a clinical nurse manager and a senior nurse to support the person in charge. The inspectors reviewed the rosters and spoke with management, staff, residents and relatives regarding the staffing levels in the centre. There had been a significant turnover of staff in the months before the inspection and recruitment was ongoing to replace nursing and health care staff. The number and skill mix of staff was not appropriate to meet the assessed needs of the 48 residents living in the centre. The inspectors saw that the activity staff member was on planned leave and was not replaced to ensure residents had access to meaningful activities in the centre. Residents and their relatives reported delays in care in the evening and over weekends. From a review of the rosters, the twilight shift was filled only four out of the seven days of the week. These and other findings are detailed under Regulation 15; Staffing.

The person in charge had arranged for face-to-face training in responsive behaviour in the centre and a group of staff attended this on the day before the inspection. The person in charge and assistant director of nursing attended training the week before the inspection to become facilitators for detecting deterioration in residents as part of a national programme. The provider had a training matrix in place to monitor staff attendance at mandatory training such as fire safety, manual handling managing responsive behaviour and safeguarding vulnerable adults. From a review of the training matrix not all staff working in the centre were detailed on the matrix as outlined under Regulation 16; Training and staff development.

From a review of a sample of staff files, it was evident that records were maintained as required under Schedule 2 of the regulations.

The inspectors found that the management systems in place to ensure oversight of the quality and safety of care provided to residents were not effective. The inspectors saw that there was a schedule of audits in place to monitor aspects of clinical outcomes for residents such as falls, weight loss and aspects of infection control standards. From review of the audits provided to the inspectors, it was evident that while these were completed up until February 2026, there were gaps in the audits since March 2026. The clinical nurse management team outlined to the inspectors that this was related to staff nursing shortages, whereby the nurse managers were covering the nursing roster in the centre. Action was also required with regard to communication systems in the centre between the provider and the person in charge as there no structured system in place to ensure the provider had oversight of the quality and safety of the services provided to residents as detailed under Regulation 23; Governance and management.

Records of incidents occurring in the centre was maintained electronically. From a review of these records, it was evident that required notifications were submitted to the office of the Chief Inspector.

The inspectors saw that the complaints procedure was displayed in the centre and records were maintained of complaints raised. Records indicated that complaints had been investigated and actioned to drive improvement to the service. However, from speaking with residents, relatives and staff, it was evident to the inspectors that issues raised as complaints such as regarding poor standard of personal care for residents or issues with the temperature in the centre were repeated. These findings are detailed under Regulation 34; Complaints procedure.

An annual review of the quality and safety of care provided to residents in 2025 had been prepared and was available for inspectors to review.

Registration Regulation 4: Application for registration or renewal of registration

The provider had submitted a complete application for renewal of registration of the centre with the required documentation.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff were not appropriate to meet the assessed needs of the 48 residents living in the centre at the time of inspection. Feedback from residents and relatives was that there were delays in care at times due to staff shortages and especially in the evening time, night time and at weekends. Other relatives reported a lack of supervision of residents in the upstairs day room in the evening and early night. The inspectors reviewed the rosters and saw that the

twilight health care positions from 6pm to 10 pm was filled only four out of the seven days of the week, leaving gaps in the roster.

The staff member assigned to activities was on two weeks annual leave at the time of the inspection and their position was not filled in the roster with a resultant lack of social stimulation and activities for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

From a review of the training matrix maintained in the centre, a number of staff required training appropriate to their role as evidenced by the following;

- A number of management staff were not on the training matrix and there was no evidence of their attendance at mandatory training
- Two staff were overdue training in the safeguarding of residents and two staff were overdue fire training
- A number of nurses were overdue training in CPR as per the centre's training requirement.

There was a lack of supervision of staff evidenced by the following findings;

- The dining room experience upstairs was very poor with little supervision by management to ensure a social dining experience for residents.
- Fire checks were signed as completed, however, the inspectors observed that a fire exit was blocked and this was not identified on the fire records.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider had a directory of residents in place that met the requirements of the regulation.

Judgment: Compliant

Regulation 21: Records

From a review of a sample of staff files, it was evident that the information required in Schedule 2 of the regulations was available.

Records were made available to inspectors as requested during the inspection.

Judgment: Compliant

Regulation 23: Governance and management

As found on previous inspections of the centre, significant concerns remained with regards the governance and management of the service and the registered provider's ability to ensure that the service provided was safe, consistent and effectively monitored.

The provider was operating the designated centre contrary to condition one of the centre's registration, on which basis the centre is registered by the Chief Inspector. Two newly commissioned offices were observed to be in use in the centre. The oratory had been relocated to the first floor from the ground floor. While an application had been submitted by the provider on 26 January 2026, the application had yet to be granted to sanction the use of these rooms. Therefore the centre was operating outside condition one of the registration as required in the Health Act.

There was evidence that the provider did not ensure that there were sufficient resources in place to meet the needs of residents, due insufficient staffing levels as outlined under Regulation 15 Staffing.

The management systems in place were not sufficiently robust to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following:

- There was a lack of oversight of fire precautions and an immediate action was issued to the provider on the first day of inspection as an escape route was not clear should a fire occur.
- There was a lack of oversight of premises issues as the inspectors found that two call bells were not in working order, the control of the temperature in the centre was raised as a complaint by residents as outlined under Regulation 17 Premises.
- There was a lack of oversight of infection control practices in the centre as outlined under Regulation 27 Infection Control.
- Communication systems across the management team were not effective or consistent. Minutes of meetings provided to the inspectors indicated that governance meetings between the provider and the person in charge were held infrequently. There were no meetings held between August 2025 and November 2025. The next meeting held was in March 2026. This did not ensure the provider had oversight of the quality and safety of care provided to residents.

- Management systems in place did not ensure residents' rights were upheld as outlined under Regulation 9; Residents' Rights.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre were maintained on an electronic system. From a review of these records, it was evident that notifications were submitted to the office of the Chief Inspector as required.

Judgment: Compliant

Regulation 34: Complaints procedure

The system in place for the management of complaints in the centre was not effective. Complaints management required action to comply with the requirements of regulations, as follows:

- While complaints were recorded as investigated and actioned, the issues raised by the complainants continued to occur. For example complaints raised by complainants with regard to the temperature in the centre was not actioned and complaints about a resident's personal care needs not being met was reported to inspectors as an ongoing concern.
- There were no records of a written response to complainants outlining the outcome of the investigation, the learnings made or the procedure to follow if a review of the complaint was required.
- These are required to meet the regulation and to ensure that complaints are fully investigated and recommendations actioned to improve the service for residents.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that although residents had good access to health care, the findings of the inspection were that ineffective governance and management systems in place, impacted the quality and safety of care provided to residents. Action was required to comply with infection control, premises, fire

precautions and residents' rights to ensure the continuing quality and safety of the service provided.

The inspectors reviewed a sample of residents' files and found that all residents had a care plan developed within 48 hours of admission as required in the regulations. Validated assessment tools were used to assess clinical risks to residents such their risk of falls, malnutrition and skin integrity. The inspectors found that a resident who was near end of life did not have pain assessment recorded. Another care plan did not reflect a resident who had recurrent falls. These and other findings will be detailed under regulation 5 Assessment and care plan.

Residents had good access to GP services from local GP practices. Residents who required assessments by allied health and social care professionals were referred to physiotherapists, occupational therapists, dietitian and speech and language services as required. Residents who developed wounds were referred for tissue viability nursing expertise.

The inspectors saw that alternatives to bed rails such as crash mats and low beds were in use. The provider was working to reduce the number of bedrails in use in the centre.

The inspectors saw that new wardrobes had been fitted in some of the bedrooms since the previous inspection and TVs had been repositioned to ensure residents could view these more easily. Two large day rooms, one on each floor had been opened and were in use for residents. These rooms were nicely decorated with large indoor plants and a large Smart TV in each of the rooms for residents' use. However, oversight of premises issues was required as the inspectors saw that two call bells were broken, stock was inappropriately stored in the centre. These and other findings are detailed under Regulation 17; Premises.

Food appeared nutritious and in sufficient quantities, drinks and snack rounds were observed morning and afternoon. Residents who spoke with inspectors gave positive feedback regarding the choice and quality of food provided. There was a rolling four week menu available and the inspectors saw that residents' meals were well presented. Action was required with regard to the dining experience as outlined under Regulation 9; Residents' rights.

Resources were available to ensure residents bedrooms were cleaned every day. The inspectors saw that residents' bedrooms and communal areas were visibly clean and residents who spoke with inspectors reported that their rooms were cleaned on a daily basis. The inspectors saw that urinary catheter bags were touching the floor for two residents. Storage in the sluice room was not in keeping with infection control practices to reduce risk of contamination. These and other findings are outlined under Regulation 27; Infection control.

Staff were provided with fire safety training on an annual basis. Simulations of evacuation of compartments in the centre were under taken on a regular basis. The fire folder was examined and daily weekly and monthly checks of fire precautions were recorded. The inspectors were not assured as to the accuracy of records confirming that the daily escape routes were clear as an immediate action was

issued to the provider on the day of inspection as an escape route was obstructed this is actioned under Regulation 28; Fire Precautions.

Residents had access to advocacy services as required. A survey seeking residents' views was conducted annually in the centre. The inspectors saw that curtains in the shared twin rooms were not positioned so that residents' privacy could be ensured. The activity co-ordinator was on annual leave for two weeks, therefore activities in the centre were limited to one hour's activities a day. These and other findings are detailed under Regulation 9; Residents rights.

Regulation 12: Personal possessions

Family members told the inspectors that they had lost items of clothing in the laundry and some personal possessions and had identified this to management but it had continued to happen.

In some residents bedrooms, wardrobes were in the bed space of other residents, which made them difficult for residents to access, if the other resident had their curtains closed or were receiving personal care.

Judgment: Substantially compliant

Regulation 17: Premises

Not all aspects of the premises conformed to the matters set out in Scheduled 6 of the regulations and in line with the statement of purpose for the centre:

- In the downstairs bathroom, adjacent to the day room, a ceiling tile was observed to be missing this was also missing on the previous inspection.
- The heating system required action to ensure that the temperature was consistent in the centre at all times. A member of staff had to manually turn on and off the heating system in the boiler house and not all staff who spoke with inspectors were aware how to do this.
- Oversight of call bells was required as the inspectors found that two call bells were not working so therefore residents could not call for assistance as required.
- Flooring on the corridors near the storage room was stained and marked.
- New locker and changing facilities upstairs for staff were not in operation despite the fact that the facilities were registered.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had not ensured that procedures, consistent with the standards for the prevention and control of health care associated infections published by the HIQA were in place and were implemented by staff as evidenced by the following;

- The inspectors saw that two urinary catheter bags were observed touching the floor which increased the risk of contamination and infection.
- Storage of commode inserts, wash hand basins and urinals required review as the inspectors saw that these were stored one on top of the other and were not placed on the available storage racks in the utility room.
- Oversight of the integrity of mattresses required action as one mattress was cracked and torn therefore could not be effectively cleaned. This mattress was visibly unclean and had a malodour, in a shared residents room.
- Stocks and products were stacked on the floors in storage rooms, therefore these rooms could not be effectively cleaned; this is a repeat finding.
- There was no evidence that outbreak reports had been compiled following outbreaks of respiratory viral infections in January and March 2026 in the centre, to ascertain if any learning could be implemented should a subsequent outbreak occur.
- There was a malodour on one of the corridors that persisted during the two days of the inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider failed to make adequate arrangements for the maintaining a means of escape for the centre. On the first day of inspection, the inspectors saw that an escape route on the ground floor was cluttered with a chair, dust mats and planks of wood and was not clear in the event of an emergency. An immediate action was issued and actioned by the provider with regard to ensuring this exit was clear. While daily checks of escape routes were recorded as clear, these did not reflect the findings of the inspectors.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall, although there were improvements since the previous inspection in relation to medication management, the inspectors observed that medications that required

a modified format such as crushing were not individually prescribed by the prescriber as such. Therefore nurses could be administering medications outside the directions of the prescriber which could lead to errors.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure assessments and care plans were updated and reflected residents' current condition as evidenced by the following;

- A falls assessment was not updated to reflect that a resident had a number of falls.
- A resident who was end of life did not have pain assessments completed to inform staff of their pain relieving requirements.
- While administration of prescribed subcutaneous fluids was recorded on the daily progress notes, total intake of prescribed subcutaneous fluids were not recorded on the care plan system nor on a paper record as required to enable assessment and monitoring of residents hydration levels.

These could lead to errors in care delivery.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors saw that residents had good access to health and social care services. Residents were reviewed regularly and as required by general practitioners. There was good oversight of wound care plans and management by the nursing care team. Residents who required community based services such as palliative care services and mental health services were referred and reviewed in the centre as required.

Judgment: Compliant

Regulation 8: Protection

Residents told the inspectors that they felt safe living in the centre. Staff spoken with were aware of what constituted abuse and how to make their concerns known

to senior management. The inspectors found that there were robust systems in place for managing residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure residents' rights were upheld in the centre, as evidenced by the following;

- The provider had not ensured that there were appropriate facilities for occupation and recreation available to residents, and that residents had opportunities to participate in meaningful group and individual activities. The activities staff member was on two weeks annual leave and staff were not rostered to replace this role on a daily basis. The inspectors saw that there was only one hour of activities on each day of the inspection in the absence of this role being filled.
- As found on previous inspections of the centre, residents living in twin rooms right to privacy was not protected, due to the positioning of the privacy screens.
- Residents were not afforded a sociable dining experience on the first floor. While the day room had been opened and there was a designated dining area now on this floor, residents sitting at dining tables were not served their meals at the same time. Eight residents were eating their meals from bed tables in the day room which did not afford them a sociable dining experience.
- Residents meetings were not held every two months as outlined in the centre's statement of purpose to ensure residents were consulted with regard to the running of the centre. Minutes of meetings provided to the inspectors indicated that two meetings had been held; one in August 2025 and one in December 2025 since the previous inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0050562

Date of inspection: 23/04/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Health Care Assistants and Nurses have been recruited since the inspection. This will ensure appropriate skill mix is maintained. 18:00 to 22:00 hours shift is rostered 7 evenings a week. We have recruited a staff member with experience as an activities co-ordinator, in order fill the position for our activities co-ordinator when she is on annual leave. This supports the safety, wellbeing and quality of care for residents.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Management are now on the training matrix and mandatory training is completed. Fire Safety Training for all newly recruited staff and staff overdue for Fire Training has been completed. CPR training for nursing staff is scheduled. Safe guarding training will be completed in the coming weeks. The dining room is now decorated with table cloths and condiments. Two hot trolleys are	

in operation to ensure all meals are distributed to all residents efficiently.

Management check the daily fire records to ensure compliance.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A Quality Controller has been assigned to oversee and ensure Quality Assurance and Compliance. Regular unannounced spot checks are being carried out over the 24-hour period, 7 days a week to improve quality and service for our residents.

Health Care Assistants and Nurses have been recruited since the inspection. This will ensure appropriate skill mix is maintained.

18:00 to 22:00 hours shift is rostered 7 evenings a week.

Management check the daily fire records to ensure compliance.

Call bells throughout the building have been audited and are functioning effectively. Daily checks are carried out by each HCA during morning care to ensure continued operation. A safety checklist has been added to TouchCare which includes call bell checks as part of the routine safety monitoring process. In addition, management conducts regular spot checks throughout the week.

Additional catheter stands have been purchased and are in use.

The utility room has now been organised appropriately.

Mattress audits have been carried out and any mattresses identified as requiring replacement will be replaced.

New shelving has been ordered to ensure no stock is stored on the floor in the storage rooms.

Going forward all reports will be made in relation to outbreaks and all learning from how the outbreak was managed will be recorded to ascertain if any learning could be implemented should any subsequent outbreak occur.

We have identified where the malodor has originated and measures were taken to address the issue. In addition, new cleaning products are in use which will eliminate odours and maintain a pleasant environment.

We have recruited a staff member with experience as an activities co-ordinator, in order to fill the position for our activities co-ordinator when she is on annual leave. This supports the safety, wellbeing and quality of care for residents.

All privacy curtains have been aligned correctly and staff have been reminded of the importance of assuring they are properly closed to maintain residents' privacy and dignity. This is monitored daily on the daily safety checklist on TouchCare.

The dining room is now decorated with table cloths and condiments. Two hot trolleys are in operation to ensure all meals are distributed to all residents efficiently. All residents are encouraged to attend the dining room for meals, however a number of residents continue to decline. We continue to support and encourage those who continue to decline in order for us to achieve full implementation of this practice.

Going forward Resident Meetings will be held every two months as outlined in the centres' Statement of Purpose to ensure residents are consulted with regard to the running of the centre.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Health Care Assistants and Nurses have been recruited since the inspection. This will ensure appropriate skill mix is maintained.

18:00 to 22:00 hours shift is rostered 7 evenings a week.

We have recruited a staff member with experience as an activities co-ordinator, in order to fill the position for our activities co-ordinator when she is on annual leave. This supports the safety, wellbeing and quality of care for residents.

Complaints are dealt with in line with our policies and procedures. A step-by-step process has been implemented to ensure consistency in the handling of complaints going forward. All communication regarding complaints will be conducted in writing to maintain a clear and accurate record of each complaint and its resolution to ensure that complaints are fully investigated, and recommendations actioned to improve the service for residents. This includes a written response to the complainant outlining the outcome of the investigation, the learnings made and procedure to follow if a review of the complaint is required.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Wardrobes are now within their own space in the shared room where residents have access to their own personal possessions without impeding the other residents space.

To help prevent any residents' personal possessions going missing in the laundry, next of kin have been contacted and asked to clearly label any new clothing and to inform staff nurse of any new clothing or personal items being brought into the home. This will enable nursing staff to accurately record residents possessions in the resident property book and this will assist laundry staff with identification to ensure personal items are returned to the correct resident.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The missing ceiling tile in the downstairs bathroom has been replaced.

Call bells throughout the building have been audited and are functioning effectively. Daily checks are carried out by each HCA during morning care to ensure continued operation. A safety checklist has been added to TouchCare which includes call bell checks as part of the routine safety monitoring process. In addition management conducts regular spot checks throughout the week.

We have requested the flooring company to repair the flooring.

The locker rooms are now in use by staff for changing before and after their shift.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Additional catheter stands have been purchased and are in use.

The utility room has now been organised appropriately. New clinical waste bins have been ordered for the utility room and we are awaiting delivery on same. All items are stored appropriately on the storage racks.

The mattress identified on the day of inspection was removed and disposed of. Mattress audits have been carried out and any mattresses identified as requiring replacement will be replaced.

New shelving has been ordered to ensure no stock is stored on the floor in the storage rooms. This will ensure that they can be effectively cleaned.

Going forward all reports will be made in relation to outbreaks and all learning from how the outbreak was managed will be recorded to ascertain if any learning could be implemented should any subsequent outbreak occur.

We have identified where the malodour has originated and measures were taken to address the issue. In addition, new cleaning products are in use which will eliminate odours and maintain a pleasant environment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Management check the daily fire records to ensure compliance. All escape routes have been decluttered and the importance of keeping fire exits clear was discussed at the staff meeting. Staff were reminded to remain vigilant and were made aware of the importance of maintaining unobstructed fire escape routes at all times. Daily inspections are being carried out by nurses, health care assistants and the Quality Control Person to ensure compliance and ongoing safety.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

All nursing staff were informed that medications that required a modified format such as crushing must not be administered without prior GP authorisation and Pharmacist approval. Nursing staff have been advised to follow this process going forward to ensure safe medication management and compliance as per policy.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All care plans are currently being reviewed and updated in accordance with residents' individual needs, and will be amended following any changes in their health status. New nurses are receiving training on falls management protocol. Post-fall assessments are being completed and documented appropriately.

A Pallative Care nurse attends end of life residents to review and administer pain relief as appropriate.

Pain assessments are being carried out for all residents who are prescribed regular pain medication.

Fluid balance reports are being documented on TouchCare and are being reviewed daily by the senior nursing team.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We have recruited a staff member with experience as an activities co-ordinator, in order to fill the position for our activities co-ordinator when she is on annual leave. This supports the safety, wellbeing and quality of care for residents.

All privacy curtains have been aligned correctly and staff have been reminded of the importance of assuring they are properly closed to maintain residents' privacy and dignity. This is monitored daily on the daily safety checklist on TouchCare.

The dining room is now decorated with table cloths and condiments. Two hot trolleys are in operation to ensure all meals are distributed to all residents efficiently. All residents are encouraged to attend the dining room for meals, however a number of residents

continue to decline. We continue to support and encourage those who continue to decline in order for us to achieve full implementation of this practice.

Going forward Resident Meetings will be held every two months as outlined in the centres' Statement of Purpose to ensure residents are consulted with regard to the running of the centre.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	19/06/2026
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	23/04/2026

	and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/06/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/07/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/06/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	30/06/2026

	the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	19/06/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	19/06/2026
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident	Substantially Compliant	Yellow	19/06/2026

	concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/06/2026
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.	Substantially Compliant	Yellow	30/06/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise	Substantially Compliant	Yellow	30/07/2026

	it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	15/07/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/04/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/04/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the	Not Compliant	Orange	30/06/2026

	designated centre concerned.			